

M e m o r a n d u m

To: Anne Gilles, Administrator
Windsor Redding Care Center
2490 Court Street
Redding, CA 96001

Date: April 9, 2012

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From: Operation Guardians
Bureau of Medi-Cal Fraud and Elder Abuse - Sacramento
Office of the Attorney General

Subject: Operation Guardians Inspection

The Operation Guardians team conducted a surprise inspection of Windsor Redding Care Center, on January 19, 2012. The following summary is based upon the team's observations, plus documents and information provided by the facility.

SUMMARY OF RESIDENT CARE FINDINGS:

Please refer to the Physician's Report for Resident Care Findings.

FACILITY ENVIRONMENTAL OBSERVATIONS:

1. Upon the team entering the facility at 7:30 AM, the facility had a strong odor of feces and urine.
2. The team observed a limited supply of linen throughout the facility during their walk-through of the building.

ADMINISTRATIVE OBSERVATIONS:

1. A nurse's note in the chart of Resident 11-07-01 was observed crossed through with an "omit" notation. It did not indicate what licensed nurse had omitted the documentation.
2. The Medical Director Agreement for Dr. Morris Ballard indicated the contract was signed with Helios Healthcare LLC, dba Redding Care Center in 2003. The contract should be updated to reflect an agreement with Windsor Corporation. It should also be noted the facility identified **three** medical directors for the facility.
3. The review of the facility's "Wound QI Log" did not have any wound tracking documentation for Resident 11-07-02. According to the nurses's notes, this resident had pressure ulcers on her left

and right buttocks requiring wound management with Hydrocolloid dressings.

4. Several of the facility residents did not appear to meet the 24-hour skilled nursing medical care requirements. The facility should be actively planning to discharge residents not meeting the skilled nursing level of care, per Title 22, to a lower level care of service. The team's review of the social services documentation for these residents did not indicate discharge planning was being implemented. This includes Residents 11-07-03 and 11-07-04.

STAFFING:

Based on the records provided by the facility, staffing levels were compliant with the 3.2 hours per resident day (hprd) on all six days randomly reviewed. The average hprd was 3.40 hours. However, providing only the minimum number of nursing hours does not always indicate quality nursing care is sufficient to meet the medical needs of the residents.

CONCLUSION:

Please be advised that this is a summary of information available to us at this time. Should further information develop from the efforts of Operation Guardians, we will notify you at the appropriate time.

The Operation Guardians inspection does not preclude any Department of Health Services complaint or annual visits, any law enforcement investigation or other licensing agency investigation or inspections, which may occur in the future. A copy of this report is being forwarded as a complaint to the Department of Health Services. This inspection does not preclude any further Operation Guardians unannounced inspection.

We do not require that you submit a plan of correction regarding the findings of the Operation Guardians inspection. However, at some future time, the contents of this letter may be released to the public.

We encourage your comments so they can be part of the public record as well. If you have any questions or any comments, please contact Cathy Long NEII, at 1425 River Park Drive, Sacramento, California 95815, phone: (916) 274-2913 or Peggy Osborn at (916) 263-2505.

Physician's Report – Operation Guardians
Kathryn Locatell, MD
April 9, 2012

Windsor Redding Care Center
January 19, 2012

The care of 11 current and former residents was reviewed, and among these cases there were three instances of concern. In one, a resident has been prescribed a number of psychotropic medications without adequate justification. In another, a resident appears to have acquired a full thickness pressure ulcer which was not staged properly by the facility. In the third, involving a resident who fell and (likely) suffered a hip fracture, the incident was not reported to the state as required.

Psychotropic medications. Resident 6 was admitted to the facility two months ago. At age 71, she has been given a diagnosis of dementia although the supporting documentation describing how this diagnosis was arrived at is not contained in the resident's chart. The resident's behaviors since admission have been escalating, with "lashing out" at caregivers among the behaviors observed. On the morning of our inspection, she was observed leaning in her wheelchair, poorly responsive/sedated in appearance, with repetitive loud moaning. Chart review shows that she had been seen by a consultant psychiatrist and a physician's assistant who have prescribed an antipsychotic drug, a benzodiazepine tranquilizer and an anticonvulsant, each of which has resulted in minimal, if any improvement. The narrative charting lacks assessment by nursing staff for potential triggers for her escalating behavior problems and functional decline since admission, and the record lacked individualized nondrug interventions.

Pressure sore. Resident 5 acquired a coccyx pressure sore since admission to the facility on 9/8/11. Chart review shows that the wound contained dead tissue that was removed (debrided) by a consultant; however, the facility had not classified the wound as a pressure sore and no care plan addressing the sore was found in the resident's chart. Interventions addressing her risk for pressure sores were listed on the care plan, but there were no revisions to reflect that she developed this wound and that it worsened with the interventions that were then in place.

Hip fracture. Resident 10 fell at her bedside just six (6) days after admission. Resident 10 had just been hospitalized for a month for treatment of a brain hemorrhage and her condition had improved markedly even before she was admitted to the facility. Although she was documented as needing minimum assistance with transfers, according to narrative charting she was ambulatory and continent of bowel and bladder. The fall occurred as the resident was attempting to apply lotion to her legs. Although there were immediate signs that she had broken her hip in the fall, and the resident's daughter returned the next day to say that the resident wouldn't be coming back to the facility, there was no documentation that anyone followed up with the hospital to determine what

Resident 10's injuries were. The incident, which obviously caused a significant injury, was not reported to the state as required, and was not listed in the facility incident and accident log.

In summary, conditions at the facility appear to reflect that an acceptable quality of care is being provided at the present time, with the few exceptions noted above. Some commendable systems of care, implemented by a new Administrator (one year since hired) and Director of Nursing (two months since hired), were observed during the inspection and residents appeared well cared for.